IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 29, 2010

Rex Redden, Administrator
Idaho Falls Group Home #1 (Bellin)
P.O. Box 50457
Idaho Falls, Idaho 83405-0457

RE: Idaho Falls Group Home #1 (Bellin), Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Idaho Falls Group Home #1 Bellin, on July 20, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 11, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

ERIC MUNDELL
Health Facility Surveyor
Fire Life Safety & Construction Program

EM/lj

Enclosure

Printed: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING 02 B. WING _____	07/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 (BELLIN)	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story Type V (000) residential building. It is sprinklered in all habitable areas with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for eight (8) ICF-MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 20, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and 42 CFR 483.470 (j). The survey was conducted by: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000	RECEIVED AUG 30 2010 FACILITY STANDARDS	
K0018	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.	K0018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Mundell REHS	Acting Administrator	9/1/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING 02 B. WING _____	07/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 (BELLIN)	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0018	Continued From page 1 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured that doors would latch upon completion of the swing to shut for one of six sleeping room doors sampled potentially affecting eight of eight residents. The census was eight. The finding includes: Observation on July 20, 2010 at 9:55 a.m. disclosed that the northeast sleeping room door would not latch upon completion of swing to shut. The latch receiver was out of adjustment and the door would not stay closed. Lack of a completely shut door would allow heat and smoke to either infiltrate the sleeping room or allow the same to be released from the interior of the room. The condition was observed by the maintenance director and surveyor.	K0018	KO 0018 1. All individuals have the potential to be affected this practice. All repairs to interior doors and other surfaces will be completed by maintenance personnel. 2. The maintenance personal will check each month when doing their home maintenance checks to ensure that all needed repairs are noted and completed. They will note each month on the maintenance checkoff sheet if repairs are needed in the home. Weekly checks will be done by the administrator to ensure that all needed repairs in the home and noted and reported to the maintenance personal for repair. Home staff will be trained to report all damage to the home supervisor so it can be reported to the maintenance personnel for repair. Administrator will follow up on all repairs on a weekly basis to enure they are being done in a timely manner. 3. This will completed by September 20, 2010	

PRINTED: 07/29/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING 02 B. WING	07/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 (BELLIN)	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The facility is a single story Type V (000) residential building. It is sprinklered in all habitable areas with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for eight (8) ICF-MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 20, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The survey was conducted by: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	M 000	RECEIVED AUG 30 2010 FACILITY STANDARDS	
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to CMS federal form 2567 and K tag K 18 regarding sleeping room doors.	MM309	MM309 Rreferal to K0018	
MM327	16.03.11.110.02(h) Emergency Electrical Service Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system.	MM327		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Ellis TITLE: Clinical Administrator (X6) DATE: 9/1/10

STATE FORM 021199 RPMO21 If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING 02 B. WING _____	07/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 (BELLIN)	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM327	Continued From Page 1 This Rule is not met as evidenced by: Based on observation it was determined the facility had not ensured that the emergency lighting was operable for one of one light tested and which potentially affected eight of eight residents. The census was eight on the day of the survey. The findings include: Observation on July 20 at 10:00 a.m. disclosed that the emergency lighting for illumination of the common area/emergency passageway did not illuminate upon pressing of the test button. Lack of lighting in a power failure would slow eight of eight residents' responses for exiting. The condition was observed by both the maintenance director and the surveyor.	MM327	~~MM327~~ 1. All individuals have the potential to be affected by this practice. All emergency lighting is in working order at this time. 2. The maintenance personal will check each month when doing their home maintenance checks to ensure that all emergency lighting is in working order. He will report any that are not to the administrator immediately so new ones can be ordered. He will turn in his monthly reports to the administrator for review. 3. This has been completed at this time. All emergency light are in working order.	9/1/10